CHILDREN COME FIRST (CCF) ADVISORY COMMITTEE

2000 ANNUAL REPORT

FOR

INTEGRATED SERVICES PROJECTS (ISP)

JANUARY 1, 2000 TO DECEMBER 31, 2000

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Executive Summary

The Children Come First (CCF) Advisory Committee is proud to present its 2000 Annual Report, highlighting the accomplishments and challenges of the Integrated Services Projects (ISP) for children with severe emotional disturbance (SED). The genesis of the ISP program in Wisconsin, which dates back to 1989 with the adoption of Wisconsin Act 31 and the creation of section 46.56, Wisconsin Statutes, addressed ISPs, and called for the establishment of an advisory committee to provide counsel and oversight to these programs.

The vision of ISPs is to create a comprehensive, flexible array of services and natural supports ensuring that children with SED remain with their families and in the community.

Background

In the United States it is estimated that one in ten children and adolescents suffer from mental illnesses severe enough to cause some degree of impairment. In Wisconsin the estimated number of children between the ages of 9 and 17 with SED is 35,510. Of this number, approximately half, or 18,255 children, will require public sector services at some point. In 2000, approximately 1,100 children were served in all of the ISPs throughout the state, and an increased number will need to be served in 2001.

Presently there are twenty-nine ISPs in Wisconsin. Nineteen counties, which comprise the smaller ISPs (on average under twelve children per program), receive some Mental Health Block Grant (MHBG) funds ($80,000 for eighteen counties and $23,800 for one county). Two additional small counties (Calumet and Sauk) operate with county-administered funds. Northwoods Alliance for Children and Families, a combination of six counties in northern Wisconsin (average enrollment 75) operates with a six-year grant from the federal Center for Mental Health Services and other funds. Wraparound Milwaukee (average enrollment 600) and Children Come First Dane (average enrollment 120) are funded through Medicaid managed care and county-administered funds. The focus of this report is on the nineteen smaller ISPs that receive funding from MHBG.

Accomplishments in 2000

Client outcomes indicated that children enrolled in ISPs functioned better in the domains of school, home, and community. Outcome data, based on a sample of twenty-one children who were enrolled during the calendar year 2000, show after six months in the program these noticeable improvements:

- 26 percent improvement in overall behavioral functioning level, measured by the Child and Adolescent Functional Assessment Scale (CAFAS)
- 17 percent improvement in living situation, measured by the Restrictiveness of Living Scale (ROLES)
- 28 percent reduction in crimes and contacts with the police
- 92 percent school attendance rate
- 40 percent reduction in unexcused school absences

The *Eight Key Components of Integrated Services* audit tool was completed during three Bureau of Community Mental Health (BCMH) clinician site visits, and seventeen self-reports were completed by ISPs. The key component audit tool is based on the values and principles of the Wisconsin system of care for children with SED and their families, section 46.56, Wisconsin Statutes. In general, the audit reports indicated positive operations in the ISPs.

Challenges for 2001

- Provide services for an increased number of children in the ISP system
- Increase family membership and voice on policy-making boards and committees in order to assist with system changes
- Expand ISP availability to children in a wider range of locales throughout the State of Wisconsin
- Increase collaboration among mental health, substance abuse, and child welfare programs through the implementation of this coordinated services approach to serve the children and families from these systems
- Implement an electronic database system to improve data collection, analysis, and reporting
- Implement performance-based contracting with ISPs
- Develop a statewide data infrastructure to capture all mental health data about children in both institutions and communities in order to enhance comparisons with national data
- Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements for transmission, storage, and handling of data

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Children Come First Advisory Committee
2000 Annual Report
for
Integrated Services Projects

Background

On January 3, 2001, the Surgeon General of the United States released a national action agenda on children's mental health in which he stated:

> "In the United States, 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. Yet, in any given year, it is estimated that fewer than 1 in 5 of these children receives needed treatment. The long-term consequences of untreated childhood disorders are costly, in both human and fiscal terms."

The Children Come First (CCF) Advisory Committee's Annual Report for the year 2000 furnishes information about mental health services provided for children under the 1989 Wisconsin Act 31. The last such report was written in December of 1991 as mandated by section 46.56, Wisconsin Statutes in Act 31(see appendix I, page 23). No subsequent reports were required for future years.

The Children Come First (CCF) Advisory Committee, developed under section 46.56, Wisconsin Statutes, was charged with monitoring "the development of programs throughout the state" and supporting "communication and mutual assistance among operating programs as well as those that are being developed..." The purpose of this report is to document some of the developments in services for Children under section 46.56, Wisconsin Statutes.

Section 46.56, Wisconsin Statutes, provided a structure for county programs to develop Integrated Services Projects (ISP) for children with severe emotional disabilities (SED). Integrated services, also referred to as "wraparound," is a process of focusing on the strengths and needs of the child and family and "wrapping" services around them to treat and support them in the community. In order to participate in an ISP program, a child must be under 18 years of age and have a severe and persistent mental, behavioral, or emotional disability that impairs his or her ability to cope with the ordinary demands of family life, school and the community, and which requires assistance from two or more service systems.

The legislation and resulting county programs are now commonly referred to as the "Children Come First" initiative. Kenosha, Marathon, Milwaukee and Waukesha counties were selected as pilot counties in April 1990. The pilots were intended to pull local agencies and service providers together into a coordinated and comprehensive system of care, overseen by a care coordinator, to meet the multiple needs of children with severe disabilities and their families. The legislation required that each program

have a coordinating committee composed of representatives from various agencies and parents whose task was the preparation of interagency agreements for participating organizations and review of program decisions. The legislation also required an administering agency of service coordination and child-specific interdisciplinary teams made up of family members, natural supports, and professionals.

In subsequent years, additional counties received funding to develop similar wraparound programs. The counties receiving funding were chosen through competitive applications to the state Department of Health and Family Services (DHFS), Bureau of Community Mental Health (BCMH). At the close of calendar year 2000, there are:

- nineteen counties receiving Mental Heath Block Grant (MHBG) funding;
- six counties funded with a six-year grant from the federal Center for Mental Health Services;
- two counties funded with Medicaid managed care capitation; and
- two counties operating with county-administered funds.

In Wisconsin, the estimated number of children between the ages of 9 and 17 with SED is 36,510. The number of children that will need public sector services is about half of that, or 18,255 children. In calendar year 2000, approximately 1,100 children were served in the nineteen smaller ISPs (on average under twelve children per program) and three larger projects; CCF-Dane (average enrollment 120), Wraparound Milwaukee (average enrollment 600) and Northwoods Alliance for Children and Families (average enrollment 75).

Core Values

Wisconsin has progressed in creating systems of care and treatment for children with SED and their families in a number of counties (see appendix II, page 29). The six core values in Wisconsin for the children's system of care are:

1. strong and explicit commitment to preserve the family unit;
2. child-centered teams with families as active team members;
3. assessment of families' strengths and needs to determine the plan of care;
4. community-based care;
5. culturally-competent care; and
6. commitment to continuous quality improvement.

Wraparound Milwaukee is one of only two programs in the nation cited as best practice models in a December 2000 report to Congress by the Coalition for Juvenile Justice. In September 2000, Bruce Kamradt, Wraparound Milwaukee Director, participated in the very first U.S. Surgeon General's Conference on Children's Mental Health. The Surgeon General's Report on Mental Health, published in 1999, also cited Wraparound Milwaukee as a best practice model of public sector managed care for mental health.

ISP Oversight

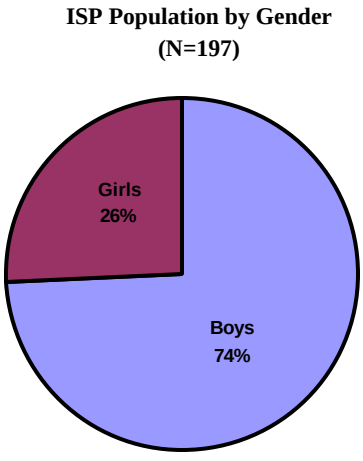
Along with other duties, clinical and fiscal oversight of the smaller ISPs is the responsibility of the DHFS, Division of Supportive Living (DSL), BCMH, Child and Adolescent Services Section. The Section includes a supervisor, two clinicians, and a finance specialist. Additionally, there are two and one-half staff in grant-funded positions.

The Child and Adolescent Services Section also has the responsibility to collect data about the children and families in these projects. The data illustrates the outcomes that occur in a variety of areas including living situations, school involvement, criminal activity and behaviors.

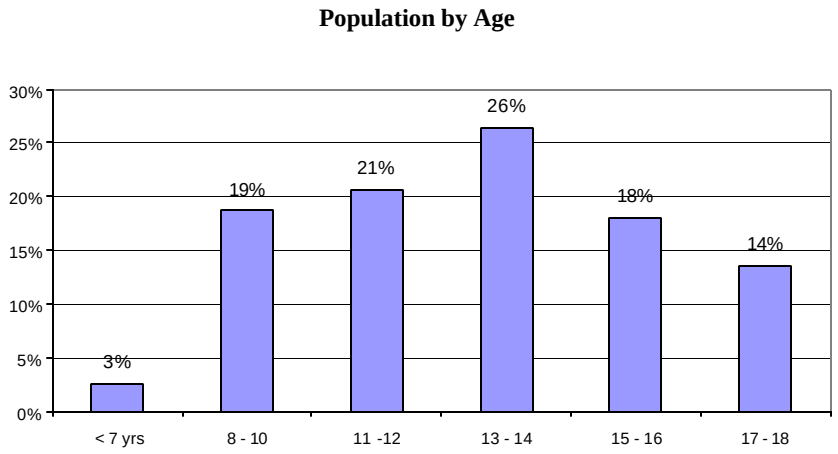
Outcome data based on a sample of 21 children who were enrolled during the calendar year 2000 show, after six months in the program, these noticeable improvements:

1. Living situation
   - 17 percent improvement in the levels of restrictiveness, measured by the Restrictiveness of Living Scale (ROLES)
2. Criminal offenses
   - 28 percent reduction in crimes and contacts with the police
3. Education
   - 92 percent attendance rate for children served by ISPs
   - 40 percent reduction in unexcused absences
4. Functioning Level
   - 26 percent improvement in overall functioning level, measured by the Child and Adolescent Functional Assessment Scale (CAFAS)

The nineteen smaller ISPs in calendar year 2000 served 197 children. The breakdown of the population by gender is 26 percent females and 74 percent males.

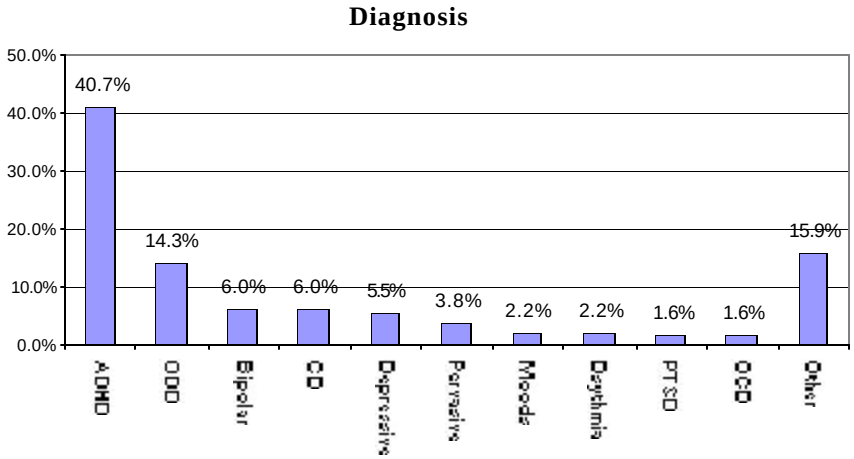


The age distribution is as follows:



Children aged 13 and 14 represent more than a quarter of the population. Children under 7 years old represent less than 5 percent of the population.

Distribution by primary diagnosis:



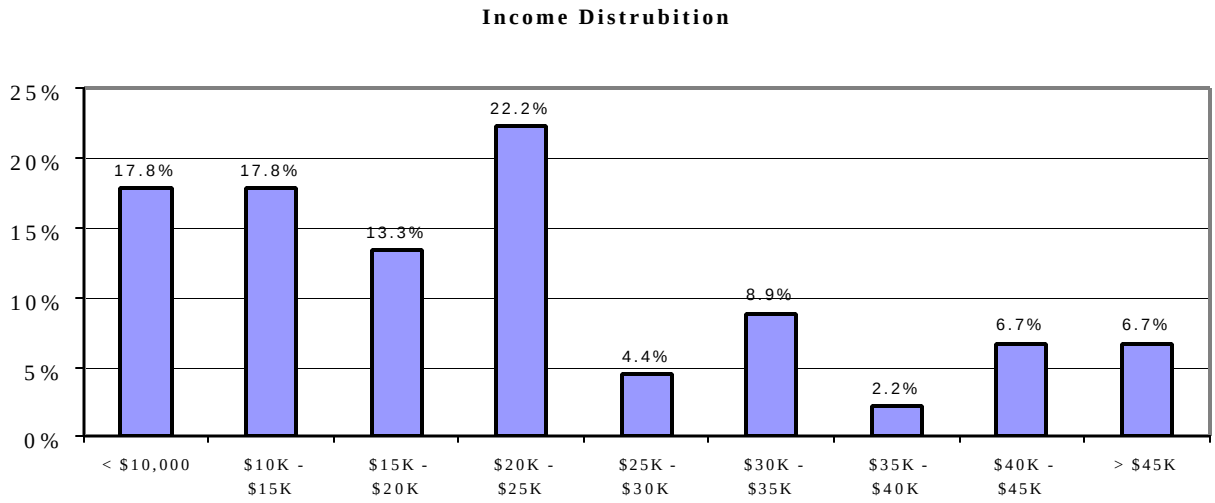
Attention deficit/hyperactivity disorder (ADHD) is by far the leading diagnosis among children in ISPs. More than 40 percent of the children have ADHD as a primary diagnosis. Oppositional defiant disorder (ODD) follows with 15 percent of the cases.

Cost information:

One major hurdle in determining full ISP costs is the difficulty of accounting for all of the natural support and indirect expenses incurred for serving children and their families in the community. It is difficult to capture the true costs of involvement from other agency staff, natural support expenses, and other community costs.

Participant family income at intake, based on a sample of 91 children, was as follows:

- Average income was $21,300
- Median income was $20,000
- Annual income for the majority of families in ISPs was $25,000 or less



Eight Key Components of Integrated Services

In 1998, a subcommittee of Project Directors from ISPs, family members and state staff developed an instrument called "Eight Key Components of Integrated Services" with performance indicators for each component (see appendix III, page 31). These key components are based on the values and principles of the Wisconsin system of care for children and adolescents with SED and their families, section 46.56, Wisconsin Statutes. When the indicators show satisfactory performance, operational evidence of the key components is observed. More importantly, when key components exist, the children and families involved receive quality care with the best practices model utilizing the wraparound/integrated service approach. The Eight Key Component review format is used in several ways: self evaluation, county requested evaluation, or BCMH evaluation.

Annually, the nineteen smaller sites are required to send to the BCMH a self report of the Eight Key Components (see appendix IV, page 40). Besides self-reporting, the Eight Key Components are completed by BCMH clinicians during their site visits.

Site Reviews

The two Child and Adolescent Services Section clinicians make two or more site reviews each year; in 2000, Door, La Crosse, Marinette, and Rock Counties were reviewed. The reviews are comprehensive and take up to a full day to complete. The site visit process is flexible, reflecting the unique nature of each ISP. The clinicians review plans of care, quarterly reports, and other records prior to a site review. The site review includes meeting with parents, advocates, service coordinators, administrators, coordinating committee members, providers, and others. The site review documents strengths, needs, and areas that require more development. Recommendations for improvements are shared with the reviewed site, and training and consultation are offered to address needs.

Report Format

The next section of this report is organized using the Eight Key Components of Integrated Services. It includes information from the nineteen smaller ISPs, seventeen Eight Key Component self reports, evaluation data, and site visits. Quotes from family members, agency directors, and others are incorporated into the sections. The section entitled **"VII. Functional goals are monitored and measured, emphasizing participant satisfaction,"** incorporates some of the evaluation data sent to the BCMH for calendar year 2000.

For additional information, please refer to the resource people listed on the contact list (see appendix V, page 44). This report will be most beneficial if you share its contents with others.

EIGHT KEY COMPONENTS OF INTEGRATED SERVICES

I. Parents are involved as full partners at every level of activity

This component includes six areas for rating and highlights the importance of full family involvement at every level of the system of care. Family members play a key role in developing and approving the plan of care, and the family participates in decisions to change the plan of care should the need arise. Family satisfaction with their participation in the program is assessed with a family satisfaction survey.

Parents are also involved in trainings, referrals and screenings. On a policymaking level, membership of the Integrated Services Programs Coordinating Committees must include at least two parents of enrolled children or parent representation equal to 25 percent of the committee's membership, whichever is greater.

The self reports from seventeen ISPs (see appendix IV page 40) indicate that the twelve ISPs are achieving all fours (always) or threes (often). Five ISPs indicated some twos (seldom) and ones (never).

Louis Pins, a Rock County parent of a seventeen-year-old special needs child wrote:

> "My family and I are living proof that the concept of a wraparound, multi-faceted approach to helping our special needs and troubled youth works beyond any shadow of a doubt….
>
> I think that the concept of working together is one that is so important in the Human Services profession. With all the resources that are available here in Rock County we will be able to serve and help so many more people if we can truly embrace the wraparound concept and not duplicate services from one department to another….
>
> While we are ultimately working for the good of the special needs children, we must not lose sight of the needs of the parents and siblings…."

Howard Harrington, Deputy Director, Waushara County Department of Human Services wrote:

> "In every instance in Waushara County in which the family became fully engaged in the process, the child and family have benefited…
>
> The most common benefit I have seen is a stronger connection to the community for the children and families. Meeting with the team over time and being treated with respect seems to give the parents more confidence in their abilities. Their whole approach to the child changes positively with this confidence and then the child improves…."

II. An inclusive Interagency Group (Coordinating Committee) serving children and families has agreed upon the core values and guiding principles that are in the interagency agreement

The coordinating committee membership is composed of parents of children with severe emotional disabilities (SED), staff of departments of social services, mental health, alcohol and other drug abuse, schools, and others. The committee assures that the core values and guiding principles of the Integrated Services Projects are followed. Meetings are held at least quarterly. Duties of the committee include preparing interagency agreements and reviewing them at least every three years, establishing eligibility criteria and reviewing program decisions.

Robert Sperling, Juvenile Justice Division Manager, Rock County Human Services Department, wrote about how the Juvenile Justice Division has benefited from moving to a family-centered, wraparound service delivery model:

> "In 1998 the Juvenile Justice Division averaged 112 children in substitute care with the Division $1.6 million dollars over budget. In 1999 the average number of children in substitute care had dropped to 80 and in 2000 the Division is averaging 60 children in substitute care. As of August 30th (2000) the Division is over $900,000 under spent in our substitute care budget….
>
> Juvenile Justice Services in Rock County have changed dramatically and in my view in a very positive manner. What began as "The Integrated Services Project" in 1993 has evolved into our service delivery model. The Division has embraced this model and the benefits are apparent for families, the Juvenile Justice Division, and the Department…."

III. Collaborative family teams create and implement individualized support and service plans of care for families

The family team includes members from home, school, and community and is consistent with family culture and preferences. Orientation is provided to all team members and training and support is provided to the team facilitator and/or service coordinator. The team develops a plan of care for the child and family that begins with an individualized strength and needs based assessment. Next, the plan follows the assessment and incorporates the strengths of the child, family and team. Responsibilities and tasks of team members are clearly identified.

Dr. Zielin, Assistant Superintendent for the New Auburn school district, wrote about a child who was released from Mendota Mental Health Institute into an ISP in Chippewa County:

> "He was then placed in a new experimental program, the Wraparound Program, one of seventeen in the state. The leader of this team has been Chris DesRosier. Under her leadership, 'D' has received the focus of an entire team of professionals….
>
> This advancement was not without difficulty. 'D' was a challenge during these years. Yet with the support of the team, we were all able to keep 'D' on a course of personal growth and development…."

Roger Klug, Children Come First Coordinator for Marquette County, wrote about the importance of collaborative teams:

> "The collaboration of agencies and individuals brought about an appreciation and awareness of other agencies. The person on the other end of the line was not a faceless, unknown bureaucrat but a person with feelings, goals, job objectives, and concerns for children, just like yourself. As communications grew, it seemed only natural to discuss other mutual concerns such as teen pregnancy, truancy, and violent teen behavior. The collaboration then became a program featuring an umbrella of mutual agency concerns….
>
> Rather than being adversaries, we became partners in the child's education and life. When crises occurred, there was a plan, there were people at the ready to come in and to calm the situation….
>
> Integrated services is not an easy solution to helping families and children get appropriate services….It means that children once ignored, forgotten, or punished will be treated as we would treat anyone who is ill or has a disability…."

Responses to a Waushara County Integrated Services Initiative evaluation stated:

> "Having agencies, families, and service providers meet regularly better ensures that needs are being met and that things are addressed before they get *too* out of hand….
>
> I believe that it's extremely important to the family and child to have meetings with all providers and have everyone working toward the same goals…."

IV. Significant collaborative funding is available to meet the financial needs identified in the plan of care

Program funding for eighteen of the Integrated Services Projects includes $80,000 of Mental Health Block Grant (MHBG) funding. By acceptance of these funds, the sites agree to provide a match of 20 percent of the $80,000. The ISP money is used for program staffing and administrative expenses, as well as flexible funding for child and family teams. Flexible funding supports individualized services to meet the goals identified in the child's plan of care.

Calumet and Sauk counties do not receive any MHBG funding from the state, but embrace the concepts of ISP and use county-administered funding to operate their programs. Chris Sieck, Deputy Director of the Department of Human Services for Calumet County, wrote:

> "Calumet County developed its integrated services project in response to a community needs assessment through the family preservation and support committee in the county. One of the highest needs identified was an integrated service delivery system and a need for better collaboration between agencies in Calumet County…
>
> Through the coordinating committee, other sources of support have been identified to supplement the budget for the program. These additional dollars have been used for flexible funding items, such as a clothes dryer for a family who did not have the mobility to easily access a laundromat on a regular basis, a birthday party for a child who has never experienced such a celebration, or for gifts at Christmas. These funds have been secured from sources such as private donations and a grant from the Community Foundation of the Fox Valley…"

V. Advocacy is provided for each family

Paid family advocates from Wisconsin Family Ties (WFT), a statewide family advocacy agency, are available in seventeen ISP counties. Families in these counties as well as the counties without paid WFT advocates are able to access information through the WFT toll free number, or the WFT Internet website. The advocates may participate as team members if requested by the family; are available to provide support, education, and advocacy services for the family; and support the team process. Another advocacy agency, Families United Inc., operates in Milwaukee County and is contracted by Wraparound Milwaukee.

Families may become involved in some form of a support network, such as a support group or a telephone tree. Families are also supported in being involved in educational events, both as participants and as presenters. Additionally, the ISP care coordinators advocate for families in many areas including court hearings, staffings, doctor appointments, etc.

Quotations from families about the roles of Family Advocates include:

> "…has been helpful in developing linkages between families and medical/therapy providers."
>
> "…was very helpful in an IEP meeting. She asked questions and got answers for me. She got me to go to other meetings to learn more about my children and how to deal with them."
>
> "…provided the information we needed to support our son so he could graduate from high school with a positive attitude and as an honor student."
>
> "…helps parents feel that they have a voice that is heard."
>
> "…is always there at our CCF team meetings and has helped us understand stuff we don't get."

VI. Ongoing training is provided to all participants

During calendar year 2000, there were local, regional, statewide, and national trainings sponsored by Integrated Services Projects and the Bureau of Community Mental Health. Local funding and Mental Health Block Grant dollars were pooled to fund the following training events:

1. ***Integrated Services: System Challenges/System Successes*** - Waushara County (April 12, 2000) - Multi-county collaborative training - 90 participants

2. ***Juvenile Justice, Mental Health and Wraparound: Bringing Them All Together*** and ***Victim Offender Conferencing*** - ISP Project Director Training (June 5, 2000) - 40 participants

3. ***Training Institutes 2000*** - National Wraparound conference held in New Orleans, LA (June 9-13, 2000) - About 50 participants from Wisconsin attended.

4. ***Developing Individual Crisis Intervention Plans*** - Waukesha County (July 2000) - 60 participants

5. ***Back to School (The good, the bad, and the sometimes ugly)*** - Waukesha County (August 23, 2000) - 40 participants

6. ***Regional Wraparound Training*** - Rock County (August 29 and 30, 2000) - 170 participants

7. ***4th Annual Crisis Intervention Conference*** - Statewide conference promoting collaboration, partnerships, and strength-based, recovery focused, crisis intervention (Sept. 21 & 22, 2000) - 410 participants

8. ***Wraparound Trainings*** - Five Regional (3-day) seminars - Each 3-day seminar included six separate modules from which participants could choose (Oct. 2–Nov. 1, 2000) - 200 participants

9. ***11th Annual Children Come First Conference*** - Statewide conference promoting Integrated Services and Wraparound as a model for system change (Nov. 9th and 10th, 2000) - 260 participants

10. ***What's sex got to do with it? Thinking about child sexual development among "normative" and "abused" children*** - ISP Project Directors training (December 4th, 2000) - 40 participants

VII. Functional goals are monitored and measured, emphasizing participant satisfaction

The ISPs utilize different types of Family Satisfaction Surveys to determine if their projects are meeting the needs of the families that are enrolled. Listed below are some of the comments that were included in these surveys.

From La Crosse County, parents wrote:

> "I feel this program is absolutely necessary for any family who has a child with special needs…"
>
> "Caring for my daughter is 24/7 – respite has helped immensely and learning to accept help from a trusted individual has relieved major stress & I am a much better person…"
>
> "Has lessened stress levels knowing I am not alone. I am sure we would have NEVER stayed as a family without this support…"

From Portage County, a parent wrote:

> "'S' (case manager) has given us new ideas about how to deal with our child. She has been great in finding the resources we had been looking for…"

From Fond du Lac County, parents wrote:

> "The ISP program is the only program that has stuck with helping our son…"
>
> "Without ISP I would not be able to keep my son. I can't do it without them…"

The BCMH has one staff person with the responsibility to collect and analyze the data submitted by the programs. During the past year an improved ISP evaluation database was developed and is being tested. The new system will allow for electronic entry and transfer of data from the various sites. This system will also provide the ISPs the capability to develop individualized data reports and will improve the analysis capability at BCMH. The following shows data results collected from the counties for calendar year 2000 in three assessment areas: restrictiveness of living environment, child and adolescent functional assessment, and number of criminal offenses.

Restrictiveness of Living Environment Scale (ROLES):

A key ISP goal is to keep children at home and in their communities. The Restrictiveness of Living Environment Scale (ROLES) shows that in the aggregate, children are living in less restrictive placement after entering the project; Figures 1 and 2 show the accomplishments of ISP in effecting desirable change in the living situations of the children served. Figure 1 shows a decrease of 17.5 percent in the level of restrictiveness of living between enrollment and six months for a sample of 21 children served in ISPs. The lower the ROLES score, the lower the level of the restrictiveness (i.e., the better the living situation). This corresponds to the data shown in Figure 2. In this graph there is an increase in the number of children living with parents or relatives in the community and a decrease of those ending up in residential care centers (RCC) and correction facilities.

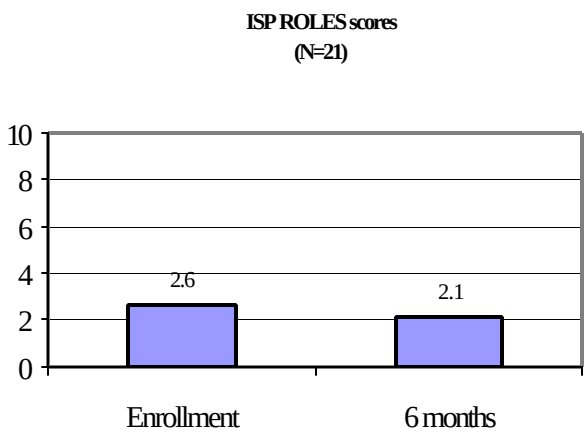


Figure 1

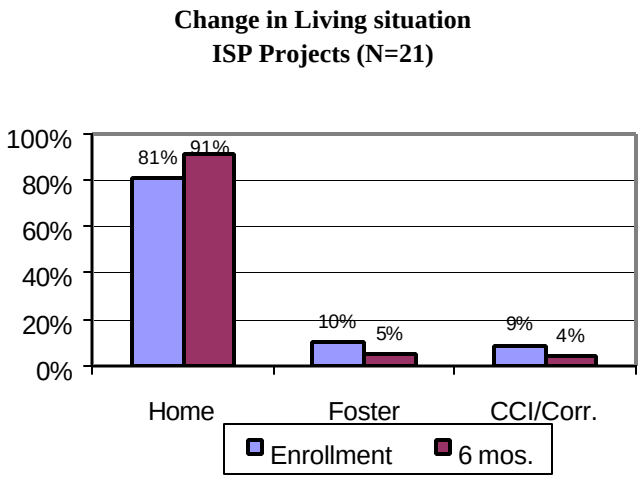


Figure 2

Child and Adolescent Functional Assessment Scales (CAFAS):

The Child and Adolescent Functional Assessment Scales (CAFAS) assesses child/youth impairment due to emotional, behavioral, mental, or substance abuse problems.

Depending on the version used, CAFAS has five or eight subscales that are assessed. They include the ability to fulfill role responsibilities at school, home, and in the community, behavior toward others, moods/emotions, self-harm behavior, substance abuse, and thinking. The lower the CAFAS scores, the lower the level of assessed impairment (i.e., the higher the functioning)

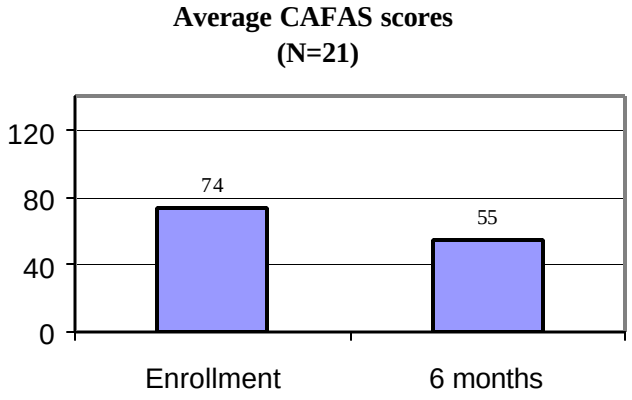


Figure 3

Figure 3 shows a significant decrease (i.e., improvement) of 26% in CAFAS scores for ISPs.

Criminal Offenses:

Criminal activity and contact with juvenile justice provide another outcome measure used to assess the performance of the ISPs. Figure 4 shows the number of criminal offenses committed between the first and third quarters of calendar year 2000 for a sample of 88 children in ISPs. There was a 28 percent decrease in the number of offenses.

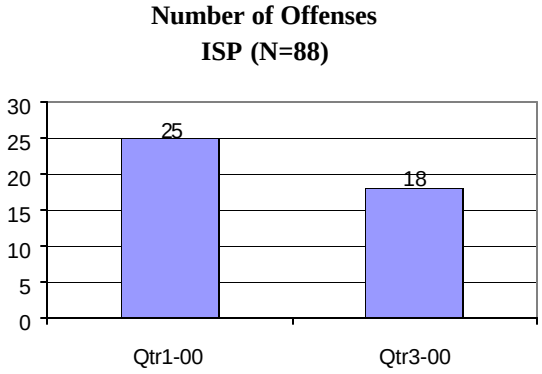


Figure 4

VIII. Adolescents are ensured a planned transition to adult life

Transition is a constant in all our lives, and children, including those enrolled in an ISP, need support to move smoothly from one grade, school, or town to another, etc. The most difficult transition, however, for young people tends to be that to independent living and is the change during which they need the most support and access to resources. Best practice models for transitioning adolescents with SED use the wraparound process.

The BCMH Child/Adolescent Section staff provide facilitation and support to the Mental Health Transition Advisory Council, a group formed to develop a comprehensive plan to improve transitioning statewide for adolescents with SED. The Transition Advisory Council meets monthly and the state contact person is Nancy Marz. The Council has been working throughout 2000 to educate themselves and form practical recommendations.

Steve Gilles, Wisconsin Department of Public Instruction, has stated:

> "Transitioning has been a school problem area in every school audit I have ever done. Some districts do a good job, others do only paper compliance. There is no uniformity of quality."

Special emphasis needs to first be given to keeping children with SED in school. Nationally, children with emotional and/or behavioral disorders have the lowest high school completion rate of any disability group. Because of this, realistic, practical Individual Educational Plans (IEPs) are needed for each child with SED.

When the child with SED becomes a teen, community agencies that will need to work with that adolescent after age eighteen should be invited to attend ISP team meetings and/or IEP meetings to prepare a clear path for transitioning that adolescent to adult life. One recommendation under consideration by the Counsel is that of using ISP coordinating committees to review all transition plans for the children enrolled in their programs. In non-ISP counties, county transition coordinating committees should be established; Cooperative Educational Service Agencies (CESAs) statewide have begun this process as a result of a contract with the Department of Public Instruction. If members of the adult service system are part of an ISP coordinating committee or a CESA-organized county transition advisory council, then they would have the opportunity to learn about numerous plans (and adolescents) without having to attend individual meetings. It would also be to the youth's advantage if local employers and representatives of other community resources served on these councils.

Eventually, Wisconsin's Mental Health Transition Advisory Council would like to see coordinating committees expand review of transition plans to include those children in out-of-home placements, involved with juvenile justice services, returning to the community from restrictive placements, etc. The Council is considering many other ideas, such as improved education of childcare providers, teachers, pediatricians and

others about childhood mental health issues, the adaptation of Community Support Programs (CSP) to attract and better serve adolescents, etc. The Council will report their recommendations in 2001.

Appendices

APPENDIX SUMMARY

Appendix I – Wisconsin Act 31, page 23

Section 46.56, Wisconsin Statutes, describes Integrated Services for children with severe disabilities. Includes information about definitions, establishment of programs, coordinating committees, needed agreements, eligibility requirements, and more.

Appendix II – Evolution of System of Care, page 29

Chart showing when Integrated Services Projects (ISP) were developed in counties from 1987 to 1999. The chart also includes key events related to Integrated Services that occurred across Wisconsin during this time period.

Appendix III – Key Components, page 31

Tool used by the ISPs and State Bureau of Community Mental Health clinicians to evaluate the ISPs. The ISP Project Directors, family members and state staff developed the tool in 1998. The instrument includes eight sections of performance indicators with a rating scale.

Appendix IV – Self Report, page 40

Summary data of the Eight Key Components completed by the ISPs in 2000, and reported to the state. The sections of the Self Report correspond with Appendix III – Key Components. Recommendations are included from each of the comment sections.

Appendix V – ISP Contact List, page 44

List of resource people who are in ISP counties, community agencies involved with the ISPs and state staff. The list provides people to contact for additional information.

Appendix I
Section 46.56, Wisconsin Statutes

46.56 Integrated service programs for children with severe disabilities.

(1) DEFINITIONS. In this section:

(a) "Administering agency" means a county department designated by the county board of supervisors to administer the program.

(b) "Agency" means a private nonprofit organization that provides treatment services for children with severe disabilities and their families.

(c) "Child with severe disabilities" means an individual who has not attained 18 years of age and whose mental, physical, sensory, behavioral, emotional or developmental disabilities, or whose combination of multiple disabilities meets all of the following conditions:

1. Is severe in degree.

2. Has persisted for at least one year or is expected to persist for at least one year.

3. Causes substantial limitations in the child's ability to function in the family, the school or the community and with the child's ability to cope with the ordinary demands of life.

4. Causes the child to need services from 2 or more service systems.

(d) "County department" means a county department under s. 46.215, 46.22, 46.23, 51.42 or 51.437, unless the context requires otherwise.

(e) "Intake" means the process by which the service coordination agency initially screens a child with severe disabilities and the child's family to see if a complete assessment is needed.

(f) "Integrated services" means treatment, education, care and support services provided, in a coordinated manner, for a child with severe disabilities and his or her family.

(g) "Integrated service plan" means the plan for treatment, education and support services for an eligible child with severe disabilities and the child's family under sub. (8) (h).

(h) "Interagency agreement" means a written document of understanding among service providers that identifies mutual responsibilities for implementing integrated services for children with severe disabilities.

(i) "Interdisciplinary team" means a group of professionals, assembled by the service coordinator, from various service systems who meet all of the following criteria:

1. Are skilled in providing treatment, education and support services for children with severe disabilities and their families.

2. Conduct comprehensive evaluations of the child with severe disabilities and the child's family's needs for treatment and support services.

3. Possess skills and knowledge of the needs or dysfunction's of the specific type presented by the child being assessed.

4. Are providing treatment, education or support services to the child with severe disabilities or the child's family, if the child or the child's family is receiving any treatment, education or support services.

(j) "Parent" means a parent who has legal custody, as defined in s. 767.001 (2), of a child, or a guardian or legal custodian of a child, as defined in s. 48.02 (8) and (11).

(k) "Program" means an integrated service program for children with severe disabilities.

(l) "Service coordination" means a case management service that coordinates multiple service providers who are serving a particular child with severe disabilities and the child's family. The term includes arrangement for assessment, development of an integrated service plan based on the assessment, advocacy for the needs of the child and the child's family, monitoring of the child's progress, facilitation of periodic reviews of the integrated service plan and coordination and maintenance of clear lines of communication among all service providers and the child and the child's family.

(m) "Service coordination agency" means a county department, agency, school district, cooperative educational service agency or county children with disabilities education board designated in an interagency agreement by a coordinating committee to provide intake and service coordination for one or more target groups of eligible children with severe disabilities and their families.

(n) "Service coordinator" means an individual who is qualified by specialized training and clinical experience with children with severe disabilities and their families and who is appointed by the service coordination agency to provide coordination of treatment, education and support services for eligible children with severe disabilities and their families.

(o) "Service system" means the public and private organizations that provide specialized services for children with mental, physical, sensory, behavioral, emotional or developmental disabilities or that provide child welfare, juvenile justice, educational or health care services for children.

(p) Treatment services" means the individualized social, emotional, behavioral and medical services designed to bring about habilitation, rehabilitation and appropriate developmental growth of a child with severe disabilities.

(2) ESTABLISHMENT OF PROGRAMS. If a county board of supervisors establishes a program under s. 59.53 (7), it shall appoint a coordinating committee and designate an administering agency. The program may be funded by the county or the county board of supervisors may apply for funding by the state in accordance with sub. (15).

(3) COORDINATING COMMITTEE. (a) The coordinating committee shall have the responsibilities specified in par. (d) and shall include representatives from all of the following:

1. The county department responsible for child welfare and protection services.

2. The county department responsible for mental health and alcohol and drug abuse services for children and families.

3. The county department responsible for providing services for children who are developmentally disabled.

4. The family support program under s. 46.985 if the county has a family support program.

5. The juvenile court administrator or another representative appointed by the judge responsible for cases heard under chs. 48 and 938.

6. The largest school district in the county and any cooperative educational service agency, if it provides special education in the county, or any county children with disabilities education board in the county, and any other school district in the county that is willing to participate in the program, at the discretion of the administering agency.

7. At least 2 parents of children with severe disabilities, or the number of parents of children with severe disabilities that it will take to make the parent representation equal to 25% of the coordinating committee's membership, whichever is greater.

(b) The coordinating committee may include any of the following:

1. Representatives of the vocational rehabilitation office that provides services to the county.
2. Representatives of a technical college district that is located in the county.
3. Physicians specializing in care for children.
4. Representatives of health maintenance organizations that are operating in the county.
5. Representatives of law enforcement agencies that are located in the county.
6. Representatives of the county health department, as defined in s. 251.01 (2).
7. Representatives of agencies that are located in the county.
(c) An existing committee within the county may serve as the coordinating committee if it has the membership required under par. (a) and agrees to undertake the responsibilities in par. (d).
(d) 1. The coordinating committee shall:
a. Prepare one or more interagency agreements in accordance with sub. (5) that all participatory organizations in the program agree to follow in creating and operating a program.
b. Assess how the program relates to other service coordination programs operating at the county or local level and take steps to work with the other service coordination programs and to avoid duplication of activities.
c. If a county applies for funding under sub. (15), assist the administering agency in developing the application required under sub. (15) (b).
d. Review determinations by the service coordination agency regarding eligibility, assessment, appropriate services, or funding of services at the request of any applicant, recipient, parent or participating county department, agency, school district, cooperative educational service agencies or county children with disabilities education boards. The committee shall adopt written procedures for conducting reviews.
2. The committee may do all of the following:
a. Act as a consortium to pursue additional funding for the program through grants from the state or federal government or private foundations.
b. Establish target groups of children with severe disabilities and their families to be served based on disability of the child, age of the child, geographic areas within the county and other factors with the approval of the department. If a county applies for funding under sub. (15), children with severe emotional disabilities are required to be a target group.
(4) ROLE OF ADMINISTERING AGENCY. The administering agency designated under sub. (2) shall do all of the following:
(a) Oversee the development and implementation of the program and designate the staff needed for the program.
(b) Assist the coordinating committee in drafting and executing interagency agreements and any other operations necessary for the start–up and operation of the program.
(c) Distribute information about the availability and operation of the program to the general public as well as to public or private service providers who might seek to make referrals to the program.
(d) If the county board of supervisors decides to seek state funding under sub. (15), develop the application in cooperation with the coordinating committee.
(e) Undertake such other activities in compliance with another provision of the statutes, department rules and guidelines, interagency agreements and the directions of the coordinating committee as are necessary to ensure the effective and efficient operation of the program.
(5) INTERAGENCY AGREEMENT. An interagency agreement shall include all of the following:
(a) The identity of every county department, agency, school district, cooperative educational service agency or county children with disabilities education board, technical college district or other organization that will participate in the program.
(b) The identification of services and resources that the participating organizations will commit to the program or will seek to obtain, including joint funding of services and funding for the qualified staff needed to support the program.
(c) The designation of service coordination agencies.
(d) The identification of any group of children with severe disabilities who will be targeted for services through the program.
(e) The procedures for outreach, referral, intake, assessment, case planning and service coordination that the program will use.
(f) The specific criteria, based on sub. (7), that will be used for deciding whether a child with severe disabilities and his or her family are eligible for services through the program.
(g) The procedures to be followed to obtain any required authorizations for sharing of confidential information among organizations providing treatment, education and support services to a child with severe disabilities and his or her family.
(h) The procedures that will be used for resolving conflicts among service providers or between clients and service providers.
(i) The methods that will be used to measure program effectiveness, including client satisfaction, and for revising the operation of the program in light of evaluation results.
(6) ROLES OF SERVICE COORDINATION AGENCY, SERVICE COORDINATOR AND INTERDISCIPLINARY TEAM. (a) There may be one or more service coordination agencies participating under the program. The organizations and the target groups that are to be served shall be identified in the interagency agreement under sub. (5). A service coordination agency shall:
1. Be selected based on the experience of the service coordination agency or its staff in providing services;
2. Identify a specific individual to act as service coordinator for each child with severe disabilities and the child's family to facilitate the implementation of the integrated service plan;
3. Provide or arrange for intake, assessment, case planning and service coordination under sub. (8); and
4. Act as a resource for information about other services for children with severe disabilities and their families who are not eligible for the program, if the coordinating committee determines that this service can be provided without interfering with the primary purpose of the program.
(b) The service coordinator shall have the functions specified in sub. (8) (f) to (i), (n) and (r).
(c) The interdisciplinary team shall have the functions specified under sub. (8) (f) and (h).
(7) ELIGIBILITY OF CHILDREN AND FAMILIES. Children with severe disabilities and their families shall be eligible for the program. The coordinating committee may establish specific additional criteria for eligibility for services and may establish certain target groups of children with severe disabilities to receive services. If target groups are established, only children with severe disabilities falling within the target groups are eligible for the program. Any eligibility criteria shall meet all of the following conditions:

(a) Be based on a community assessment that identifies areas of greatest need for integrated services for children with severe disabilities.
(b) Give priority to children with severe disabilities who are at risk of placement outside the home or who are in an institution and are not receiving integrated community–based services, or who would be able to return to community placement or their homes from an institutional placement if such services were provided.
(c) Not exclude a child with severe disabilities or that child's family from services because of lack of ability to pay.
(8) REFERRAL, INTAKE, ASSESSMENT, CASE PLANNING AND SERVICE COORDINATION.
(a) Referrals to the program may come from any county departments, agencies, school districts, cooperative educational service agencies, county children with disabilities education boards, technical college districts, courts assigned to exercise jurisdiction under chs. 48 and 938 or any other organization or the child with severe disabilities or his or her family may contact the administering agency or service coordination agency to request services.
(b) Upon referral, staff from the service coordination agency shall screen the referral to determine if the child with severe disabilities and the child's family appear to meet the eligibility criteria and any target groups established by the coordinating committee. If the child with severe disabilities and the child's family appear to be eligible, the staff shall gather information from the child's family and any current service providers to prepare an application for the program.
(c) Consent for release of information and participation of a child with severe disabilities and his or her family in the program and in the program evaluation must be obtained from the child's parent, or the child, if appropriate or required, or by order of a court with appropriate jurisdiction.
(d) The service coordination agency shall review the completed application and, in light of the eligibility criteria in the interagency agreement and sub. (7), determine whether the child with severe disabilities and the child's family are appropriate for services through the program. The service agency shall approve or disapprove each application within 30 days after the date on which the application was received.
(e) If the child with severe disabilities and the child's family are found to be ineligible, staff from the service coordination agency shall assist them in obtaining needed services from appropriate providers.
(f) If the child with severe disabilities and the child's family are found to be eligible for the program, the agency shall assign a service coordinator who shall assemble an interdisciplinary team to assess the child with severe disabilities and the child's family's need for treatment, education, care and support.
(g) The service coordinator shall assemble the results of all prior relevant assessments and evaluations documenting the service needs of the child with severe disabilities and the child's family, including individualized education program team evaluations under s. 115.782 or independent educational evaluations, court– ordered evaluations under s. 48.295 or 938.295, family support program evaluations, community integration program or community options program assessments, and any other available medical, psychiatric, psychological, vocational or developmental evaluations.
(h) The interdisciplinary team, the family of the child with severe disabilities and the service coordinator shall, based on existing assessments that have been assembled and any additional evaluations that they or the family find to be necessary, prepare an integrated service plan within 60 days after the date on which the application was received. The integrated service plan shall include all of the following:
1. The child's present level of functioning expressed in objective terms that will permit ongoing evaluation of the child's progress.
2. The short–term and long–term goals for treatment and support services for the child with severe disabilities and the child's family.
3. The services needed by the child with severe disabilities and the child's family, including the identity of each organization that will be responsible for providing a portion of the treatment, education and support services to be offered to the child and the child's family, and the specific services that each organization will provide.
4. Criteria for measuring the effectiveness and appropriateness of the integrated service plan so that it can be modified as needed to better meet the child's and the child's family's needs.
5. Identification of any administrative or judicial procedures under ch. 48, 51, 55, 115, 118 or 938 that may be necessary in order to fully implement the integrated service plan and the identity of the individual or organization that will be responsible for initiating those procedures, if any are required.
6. Identification of available sources of funding to support the services needed for the child with severe disabilities and his or her family and an allocation of funding responsibility among organizations where more than one organization is responsible for the child's and the child's family's treatment, education and support services.
(i) If additional evaluations are needed, the service coordination agency shall arrange for them or assist the child's family in obtaining them.
(j) The proposed integrated service plan shall be submitted to any service providers who would be included in the integrated service plan and the court assigned to exercise jurisdiction under chs. 48 and 938 if participation in the program has been court ordered under s. 48.345 (6m) or 938.34 (6m).
(k) Upon written approval of the integrated service plan by the proposed service providers and the child's family, unless the child's involvement in the program is through court order under s. 48.355 or 938.355, in which case approval of the court may be substituted for that of the family, the integrated service plan shall be implemented by the service coordination agency and the service providers designated to provide services under the integrated service plan.
(l) In providing integrated services under this section, the service coordination agency and the designated service providers shall include in the integrated service plan all individuals who are active in the care of the child with severe disabilities, including members of the child's family, foster parents, treatment foster parents and other individuals who by close and continued association with the child have come to occupy significant roles in the care and treatment of the child with severe disabilities.
(m) Each service provider designated to provide services under the integrated service plan shall identify a specific staff person who shall serve as the ongoing member of a treatment team to ensure continuity and communication while services are being provided to the child with severe disabilities and his or her family under the integrated service plan. The service coordinator shall coordinate the operations of the treatment team.
(n) The service coordinator shall advocate for the child with severe disabilities and the child's family and ensure that they are provided the opportunity to participate in assessment, planning and ongoing review of services to the fullest extent possible.

(o) Services under this section shall be provided in the community in the least restrictive and least intrusive setting and manner which meets the best interests of the child with severe disabilities.
(p) An integrated service plan shall not be used to place or accomplish the placement of a child with severe disabilities outside his or her home. Any out–of–home placements may occur only under the statutory provisions specifically controlling such placements or admissions.
(q) An integrated service plan may not modify an individualized education program created for a child with severe disabilities under ch. 115. The integrated service plan shall coordinate any educational services that are being provided to the child with severe disabilities with any treatment and support services that are being provided to the child with severe disabilities and that child's family.
(r) The service coordinator shall, when necessary and at least every 6 months, assemble the treatment team, the family of the child with severe disabilities, the child with severe disabilities, where appropriate, and any counsel, guardian ad litem or other person advocating for the interests of the child with severe disabilities or the child's family to review the integrated service plan, progress toward the goals of the integrated service plan, establish new goals, request the inclusion of new participating organizations, or otherwise modify the integrated service plan to better meet the needs of the child with severe disabilities and the child's family. Decisions to amend the integrated service plan must be approved by the service coordinator, the treatment team, the family and, where the integrated service plan is being provided under a court order, by the court.
(s) Services under the integrated service plan may be terminated by the agreement of all participants that the goals of treatment and support have been met and that an integrated service plan is no longer needed, by order of the court if services are being provided under court order, by withdrawal of the family of the child with severe disabilities unless participation is court ordered, or by the service coordination agency upon a recommendation from the service coordinator and the treatment team, that further services are not in the child's best interests, or that the child with severe disabilities and child's family no longer meet the eligibility criteria for the program.
(9) IMMEDIATE CARE. Individual county departments, agencies and other service providers may provide immediate services as necessary and appropriate to children with severe disabilities who have been referred for participation in the program while assessment and planning take place.
(10) RELATION TO FAMILY SUPPORT PROGRAM. In any county that has a family support program under s. 46.985, the integrated service program shall coordinate its activities with the family support program. The administering agency for the family support program may act as a service coordination agency for the integrated service program and the family support program advisory committee may act as the coordinating committee if the requirements of this section are met and the department gives its approval.
(11) INFORMAL CONFLICT MANAGEMENT. The department, administering agency, service coordination agencies and service coordinators shall establish and use informal means for conflict management, including consultation, mediation and independent assessment, whenever possible.
(12) ADMINISTRATIVE APPEALS. Decisions by the service coordination agency regarding eligibility, denial, termination, reduction or appropriateness of services may be appealed to the coordinating committee by a child with severe disabilities who is a service applicant or recipient or the parent or guardian or guardian ad litem of the applicant or recipient. Decisions of the coordinating committee may be appealed to the department under ch. 227.
(13) REVIEW OF ACTIONS BY INDIVIDUAL AGENCIES. Nothing in this section shall limit, modify or expand the rights, remedies or procedures established in federal or state law for individuals or families receiving services provided by individual organizations that are participating in the integrated service plan.
(14) DUTIES OF DEPARTMENT.
(a) In order to support the development of a comprehensive system of coordinated care for children with severe disabilities and their families, the department shall establish a statewide advisory committee with representatives of county departments, the department of public instruction, educational agencies, professionals experienced in the provision of services to children with severe disabilities, families with children with severe disabilities, advocates for such families and their children, the subunit of the department of workforce development that administers vocational rehabilitation, the technical college system, health care providers, courts assigned to exercise jurisdiction under chs. 48 and 938, child welfare officials, and other appropriate persons as selected by the department. The department may use an existing committee for this purpose if it has representatives from the listed groups and is willing to perform the required functions. This committee shall monitor the development of programs throughout the state and support communication and mutual assistance among operating programs as well as those that are being developed.
(b) The department shall provide, either directly or through purchase of services, the following support services to the counties that elect to participate in the program:
1. Consultation in the areas of developing individual integrated service plans, finding appropriate resources, and establishing and maintaining local programs.
2. Mediation to assist in the management of conflict among service providers or funding organizations or between service recipients and organizations.
3. Assessment resources for cases where no local evaluation resource is available or sufficient to enable development of an effective integrated service plan. These may be provided directly through state–operated programs or by referral to private service providers.
(c) The department shall evaluate the programs funded under this section. All organizations participating in the program shall cooperate with the evaluation. The evaluation shall include information about all of the following:
1. The number of days that children with severe disabilities served in the programs spent in out–of–home placement compared to other children with severe disabilities in the target group.
2. Whether or not the program's goals under sub. (15) (e) have been met and the program's plan for allocating funding from institutional services to community–based services for children with severe disabilities has been implemented.
3. A comparison between any changes in problem behaviors of participants before and after participation in the program.
4. A comparison between school attendance and performance of participants before and after participation in the program.
5. A comparison between recidivism rates of participants who have a history of delinquency.
6. Parent and child satisfaction with the program.

7. Types of services provided to children with severe disabilities and their families in the program through the integrated service plan and the cost of these services.
8. Fulfillment of the terms of the interagency agreements developed by the coordinating committee. (d) Notwithstanding sub. (1) (c) (intro.), if the state is funding the program in a particular county under sub. (15), the department may permit the county to serve any individual who has severe disabilities and who has not attained 22 years of age if the individual's mental, physical, sensory, behavioral, emotional or developmental disabilities or whose combination of multiple disabilities meets the requirements specified in sub. (1) (c) 1. to 4.
(15) FUNDING.
(a) From the appropriation under s. 20.435 (7) (co), the department shall make available funds to implement programs. The funds may be used to pay for the intake, assessment, case planning and service coordination provided under sub. (8) and for expanding the capacity of the county to provide community– based care and treatment for children with severe disabilities.
(b) In order to apply for funds under this section the county board of supervisors shall do all of the following:
1. Establish a coordinating committee and designate an administering agency under sub. (2).
2. Establish children with severe emotional disturbances to be the priority target group served by the program.
3. Submit a plan to the department for implementation of the integrated service program in accordance with the requirements of this section.
4. Submit a description of the existing services in the county for children with severe disabilities, an assessment of any gaps in services, and a plan for using the funds under this program or from other funding sources to develop or expand any needed community– based services such as in–home treatment, treatment foster care, day treatment, respite care or crisis services.
(c) In order to obtain funds under this section, matching funds equal to 20% of the requested funding shall be provided by the participating county departments and school districts. All of the participating county departments and school districts shall participate in providing the match, which may be cash or in–kind. The department shall determine what may be used as in–kind match.
(d) In order to apply for funding, at least one school district, cooperative educational service agency or county children with disabilities education board serving children with severe disabilities in the county must participate in the program.
(e) During the first year of funding under this section, the coordinating committee and the administering agency shall develop and submit to the department, for its approval, a set of goals for diverting children with severe disabilities from placements outside the home and a plan for allocating funding from institutional services to community–based services for children with severe disabilities. The coordinating committee and the administering agency shall also ensure that any funds saved, during the course of the program, as a result of the reduced use of institutional care by the target population will be allocated to community–based services for the target population.
(f) Funds allocated under this subsection may not be used to replace any other state and federal funds or any county funds that are being used to fund services for children with severe disabilities. History: 1989 a. 31; 1993 a. 27, 399, 446; 1995 a. 27 ss. 2317, 2318, 9130 (4), 9145 (1); 1995 a. 77, 201; 1997 a. 3, 27, 114, 164.

Appendix II
The Evolution of a Comprehensive, Flexible and Community-based System of Care in Wisconsin

The Evolution of a Comprehensive, Flexible and Community-based System of Care in Wisconsin

YEAR	1987-88	1989	1990-92	1993	1994	1995-96	1996-1997	1997-98	1999-2000
Counties Starting New ISPs	Dane Kenosha (Small Case Management Projects)	WI's CCF Law, Wis. Stats., s. 46-56 Enacted	Marathon (now NACF) Waukesha Racine Milwaukee	Dunn Marinette Waushara Marquette Fond du Lac	Rock Washington Sheboygan Eau Claire Chippewa Ashland	La Crosse Washburn Vilas Oneida Forest (now NACF)	Waupaca	Door Portage Langlade Lincoln (through NACF)	Calumet Sauk Brown Outagamie Douglas
KEY EVENTS	Both Dane and Kenosha received federal CASSP dollars from a five-year grant (1984-89) to start small community case management projects.	The "Children Come First" (CCF) law is created in state statutes, authorizing and funding the creation of Integrated Services Programs (ISPs).	Dane Co. and the State of WI received a joint grant through Robert Wood Johnson Foundation to create an ISP. Starting in 1992, Dane received reimbursement from Medicaid for hospital diversions.	Dane County's Project FIND becomes a public sector, capitated, managed, behavioral health carve-out called CCF managed care. In 1993, CCF managed care is not at risk and covers community-based treatment and case management, but not inpatient hospital treatment.	Milwaukee's ISP was expanded to become Wraparound Milwaukee with a CMHS $15 million grant over five years. In 1994, Dane Co. CCF which is a managed care program, added inpatient hospitalization coverage along with community-based treatment and case management.	Milwaukee will receive reimbursement from Medicaid for hospital diversions. Milwaukee is operating as a managed behavioral health carve-out for some revenues and all expenditures. It is scheduled to receive capitated payments for all revenues in 1997.	Milwaukee is capitated, becomes a care management organization in March 1997. Waupaca County receives a Systems Change Grant to establish a system of care for children with SED and their families.	Langlade and Lincoln received federal grant funding in Sept. 1997, along with four other counties making up the Northwoods Alliance for Children & Families (NACF). This freed up ISP grant funds, which were given to Door and Portage Counties.	Calumet and Sauk operate ISPs without grant funds, using county-administered funds only. They have requested and received technical assistance from BCMH for the development of their ISPs. Brown Outagamie, and Douglas are currently under development.
Total ISPs	2	0	6	11	17	22	23	27	32

Appendix III
Eight Key Components of Integrated Services

I. Parents* Are Involved as Full Partners at Every Level of Activity (*The term "parent" represents all caregivers*)			
Team Participation			
Indicators	**Suggested Information Source** ✓ ***sources utilized***	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Parents may request meetings.	☐ Parents ☐ Family Satisfaction Survey ☐ Service Records	4 3 2 1	
2. Parents are present @ team meetings. Children are present whenever possible and appropriate.	☐ Service Coordinator ☐ Parents ☐ Service Records ☐ Family Satisfaction Survey	4 3 2 1	
3. Parents' needs are considered in scheduling meetings.	☐ Service Coordinator ☐ Parents ☐ Family Satisfaction Survey ☐ Service Records	4 3 2 1	
4. Parents are involved in selection of team members.	☐ Service Coordinator ☐ Family Satisfaction Survey ☐ Parents	4 3 2 1	
Coordinating Committee Participation			
1. Parents on Coordinating Committee and appropriate subcommittees.	☐ Administrating Agency ☐ ISP Director ☐ Committee Reports/Minutes	Yes No	
2. Parents attend at least 75% of scheduled meetings.	☐ Administrating Agency ☐ ISP Director ☐ Committee Reports/Minutes	4 3 2 1	
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	☐ Parents ☐ Family Satisfaction Survey ☐ Service Coordinator	4 3 2 1	

Recommendations: _____

II. An Inclusive Interagency Group (Coordinating Committee) Serving Children and Families Has Agreed Upon the Core Values and Guiding Principles Which Are in the Interagency Agreement			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Agreement incorporates all the members and components listed under State Section 46.56, Wis. Stats. (3) (5).	☐ ISP Director ☐ Coordinating Committee ☐ Interagency Agreement	Yes No	
2. The Coordinating Committee reviews interagency agreements at least every three years.	☐ Committee Minutes ☐ Updated agreement	Yes No	
3. Coordinating Committee meets at least quarterly.	☐ Administrating Agency ☐ Committee Minutes ☐ ISP Director	Yes No	
4. Conflict resolution policies are clearly written and reviewed at least annually.	☐ Administrating Agency ☐ Coordinating Committee ☐ ISP Director	Yes No	
5. Conflict resolution policies are followed when disagreements arise.	☐ Administrating Agency ☐ Coordinating Committee ☐ ISP Director ☐ Family Satisfaction Survey	Yes No	
6. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	☐ Administrating Agency ☐ Coordinating Committee ☐ ISP Director ☐ Parents	4 3 2 1	
7. Collaborating agencies are satisfied with process.	☐ Provider Survey ☐ Coordinating Committee	4 3 2 1	

Recommendations: _____

III. Collaborative Family Teams Create and Implement Individualized Support and Service Plans of Care for Families			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Orientation is provided to all team members.	☐ Service Coordinator ☐ Team Survey ☐ Family Satisfaction Survey	Yes No	
2. Team facilitator and/or service coordinator receive training and support.	☐ Service Coordinator ☐ Team Survey ☐ Family Satisfaction Survey	4 3 2 1	
3. Collaborative family team includes membership from home, school & community.	☐ Service Coordinator ☐ Team Survey ☐ Plan of Care ☐ Family Satisfaction Survey	4 3 2 1	
4. Team composition is consistent with family culture and preferences.	☐ Service Coordinator ☐ Team Survey ☐ Family Satisfaction Survey	4 3 2 1	
5. Family is satisfied with its team.	☐ Service Coordinator ☐ Team Survey ☐ Family Satisfaction Survey	4 3 2 1	
6. Family is satisfied with the team process.	☐ Service Coordinator ☐ Team Survey ☐ Family Satisfaction Survey	4 3 2 1	
7. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	☐ Service Coordinator ☐ Team Members ☐ Family Satisfaction Survey	4 3 2 1	
8. Plan of care flows from assessment.	☐ Service Coordinator ☐ Team Members ☐ Plan of Care	4 3 2 1	
9. Plan of care incorporates strengths of child, family and team.	☐ Service Coordinator ☐ Team Members ☐ Plan of Care	4 3 2 1	

III. Collaborative Family Teams Create and Implement Individualized Support and Service Plans of Care for Families			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
10. The plan of care includes specific actions to meet identified needs, including who is responsible (including parents) for completing the action, and the plan is being followed.	☐ Service Coordinator ☐ Parents ☐ Family Satisfaction Survey ☐ Plan of Care	4 3 2 1	
11. Family and other team members sign Care Plan.	☐ Service Coordinator ☐ Plan of Care	Yes No	
12. Transition is addressed for major life changes.	☐ Plan of Care ☐ Team Members ☐ Service Coordinator	4 3 2 1	

Recommendations: _____

IV. Significant Collaborative Funding is Available to Meet the Financial Needs Identified in the Plan of Care			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Agencies contribute resources and funding to meet the needs of families.	☐ Coordinating Committee ☐ Family Satisfaction Survey ☐ Administrating Agency ☐ Quarterly Report	4 3 2 1	

IV. Significant Collaborative Funding is Available to Meet the Financial Needs Identified in the Plan of Care			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
2. Child and family teams use funding flexibly to support individualized service.	☐ Coordinating Committee ☐ Family Satisfaction Survey ☐ Administrating Agency ☐ Quarterly Report	4 3 2 1	
3. Child and family team accesses informal community resources.	☐ Coordinating Committee ☐ Plan of Care ☐ Administrating Agency ☐ Quarterly Report ☐ Family Satisfaction Survey	4 3 2 1	

Recommendations: _____

V. Advocacy Is Provided For Each Family			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Family advocacy information and options are provided.	☐ Families ☐ Advocates ☐ Family Satisfaction Survey	Yes No	
2. Advocates may participate as team members as requested by the family.	☐ Families ☐ Advocates ☐ Family Satisfaction Survey	Yes No	

V. Advocacy Is Provided For Each Family			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
3. Service Coordinators advocate for families	☐ Families ☐ Service Coordinator ☐ Family Satisfaction Survey	4 3 2 1	

Recommendations: _____

VI. Ongoing Training is provided to all Participants			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	☐ Service Coordinator ☐ Coordinating Committee	Yes No	
2. Annual local training opportunities are made available to families, staff and all others involved with the ISP process.	☐ State Staff ☐ ISP Director ☐ Family	Yes No	

Recommendations: _____

VII. Functional Goals are Monitored and Measured, Emphasizing Participant Satisfaction			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. Generally, outcomes show: a. A decrease in police contact/recidivism rates. b. Maintenance or decrease in level of restrictiveness of living situation c. Improvement in grades d. Improvement in attendance. e. Decrease in problem behaviors.	Quarterly Report	a. Yes No b. Yes No c. Yes No d. Yes No e. Yes No	
2. Plan reviews are held at least every six months.	☐ Service Coordinator ☐ Plan of Care	Yes No	
3. Family is satisfied with process.	☐ Family Satisfaction Survey	4 3 2 1	
4. Family is satisfied with outcomes.	☐ Family Satisfaction Survey	4 3 2 1	
5. Providers are satisfied with process.	☐ Provider Satisfaction Survey	4 3 2 1	
6. Providers are satisfied with outcomes.	☐ Provider Satisfaction Survey	4 3 2 1	

Recommendations: _____

VIII. Adolescents Are Ensured a Planned Transition to Adult Life			
Indicators	**Suggested Information Source** ✓ *sources utilized*	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Rating**	**Comments**
1. A mechanism is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	☐ Service Coordinator ☐ Coordinating Committee ☐ Team Members	Yes No	
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	☐ Project Directors ☐ Plan of Care ☐ Team Members	Yes No	
3. For the most seriously ill adolescents, within 1 year of transition to adult living: a. Action steps are clearly defined, b. Needed referrals have been made c. Future collaborators are invited to team meetings.	☐ Plan of Care ☐ Service Coordinator	a. 4 3 2 1 b. 4 3 2 1 c. 4 3 2 1	

Recommendations: _____

Appendix IV
ISP Self Report
Summary of Eight Key Components

ISP SELF REPORT SUMMARY
of
EIGHT KEY COMPONENTS OF INTEGRATED SERVICES

Rating scale: 4 = Always, 3 = Often, 2 = Seldom, 1 = Never

I. Parents are involved as full partners at every level of activity:
   A. All 4s and 3s----------12 ISPs
   B. Some 2s and 1s----------5 ISPs
   C. Recommendations/Comments:
      1. Encourage parents to request meetings.
      2. Need children to attend team meetings.
      3. Need parents on coordinating committee.
      4. If parents are too busy to attend coordinating committee meetings, get their input at team meetings.
      5. No parent=no meeting.
      6. Parents should be encouraged to invite others.
      7. Five out of 15 members on coordinating committee are parents, but they don't always attend.
      8. Meetings are usually in the home/scheduled based on availability of parents.
      9. Parents are always invited but don't always come (no parents, no decisions).
      10. Parents don't always come to coordinating committee meetings (will try to add more and use county members crisis plan development).

II. Inclusive interagency group (coordinating committee) serving children and families has agreed upon the core values and guiding principles that are in the interagency agreement:
   A. All 4s and 3s----------12 ISPs
   B. Some 2s and 1s----------5 ISPs
   C. Recommendations/Comments:
      1. Need to review conflict resolution polices each year.
      2. Need to address ensuring that core values are evident in practice.
      3. Just rewrite the interagency agreement.
      4. Committee meets 8 times a year.
      5. Committee meets 6 times per year.
      6. Committee meets 3 times per year.
      7. Will be doing formal provider survey satisfaction survey this year.
      8. Sense of good cooperation.

III. Collaborative family teams create and implement individualized support and service plans of care for families:
   A. All 4s and 3s (except transitional planning)----------13 ISPs
   B. Some 2s and 1s----------4 ISPs
   C. Recommendations/Comments:
      1. Need to develop orientation for facilitator and team members.

2. Need all team members to sign orientation plan.
3. Need to increase school orientation and collaboration.
4. Need to develop strength-based assessment and planning.
5. Team member tasks and responsibilities are not stated.
6. Treatment plans more expansive than state form allows.
7. Tasks and responses identified in team minutes and profilers notes.
8. State form doesn't accommodate specific actions, etc.
9. Include strengths of family as well as the child.

IV. Significant collaborative funding is available to meet the financial needs identified in the plan of care:
   A. All 4s and 3s----------13 ISPs
   B. Some 2s and 1s----------4 ISPs
   C. Recommendations/Comments:
      1. Need to address collaborative funding from all partner agencies.
      2. Need to develop utilization of informal resources.
      3. Collaborative funding routine regarding mentoring and respite.
      4. Schools help, as does United Way and Family Preservation.
      5. Would like to see more flexible funding at state and federal levels.
      6. Funding tends to be categorical; ISP funds flexible.

V. Advocacy is provided for each family:
   A. All 4s and 3s----------13 ISPs
   B. Some 2s and 1s----------4 ISPs
   C. Recommendations/Comments:
      1. Need to provide advocacy information.
      2. Include information in orientation packet.
      3. Encourage parents to use the resources of ARCH, NAMI, MHA, Parents' Place, etc.
      4. Family Ties advocate has attended meetings.
      5. Address differences between what the family wants and what the team thinks is best.

VI. Ongoing training is provided to all participants:
   A. All 4s and 3s----------15 ISPs
   B. Some 2s and 1s----------2 ISPs
   C. Recommendations:
      1. Need to encourage parental participation at trainings and conferences.
      2. On many levels, ongoing clinical inservices are needed.
      3. Need more local training for families.
      4. Need training that is more specific to program.

VII. Functional goals are monitored and measured, emphasizing participant satisfaction:
   A. All 4s and 3s----------12 ISPs
   B. Some 2s and 1s----------5 ISPs
   C. Recommendations/Comments:
      1. Need to develop satisfaction survey.
      2. Need to revise provider survey.
      3. Need to review plans at least every six months.
      4. Targeted population has low crime/police contact rate generally.
      5. Annotated data indicates high level of satisfaction.
      6. Family satisfaction survey gets high marks.

VIII. Adolescents are ensured a planned transition to adult life:
   A. All 4s and 3s----------13 ISPs
   B. Some 2s and 1s----------3 ISPs
      One not applicable (only works with young children)
   C. Recommendations/Comments:
      1. Need to improve identification and transitional planning for youth aged 15 and older.
      2. Address complaints that the focus is only on kids aged 14 and younger.
      3. Adolescent to adult transition is most difficult and problematic area; planning to assign staff to work on this.
      4. Adult services are reluctant to take referrals more than 2-3 months before child turns 18.
      5. Working on improving process and training.
      6. Think new day treatment supervisor (J S) will work with team
      7. Use Independent Living Skills assessment.
      8. CCF staff meet with adult workers to discuss/plan needed care beyond age eighteen.

Appendix V
Integrated Services Projects
Contact List

INTEGRATED SERVICES PROJECTS
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